## **Exhibit BB**



Jay T. Segarra, M.D., FACP

NIOSH Certified B-Reader

Board certified in Internal Medicine, Pulmonary Diseases, & Critical Care Camellia Place • 2123 Government Street • Ocean Springs, Mississippi 39564
Phone/Fax (228) 872-2411

DATE OF RADIOGRAPH MONTH DAY YEAR	1/11 1.6.	r	
111 09 2004	Netter, John	E.	
WORKER'S Social Security Number	RORNTGENORGRAPHIC INTERPR TYPE OF READING	RETATION	PACILITY IDENTIFICATION
Note Please record your telespectation of a single film by			BCH
Special se _x, so me shicolassi poses on this goal"	A B P		
L PILM QUALITY Overexposed (dark)	Improper position U	indecia (Intion	
1 3 RIR Underexposed (light)	Poor contrast M	intile	
(If not Grade 1, mink all Artifacts boxes that apply)	Poor processing O	ther (please specify)	
2A. ANY PARENCHYMAL ABNORMALITIES CONSISTENT WITH PREUMOCONIOSIS7	•	CES Champleia Sentions 28 and 2C	NO Proceed to Section 3A
2B. SMALL OPACITIES b 20NES	c PROPUSION	2C. LARGE OPACITIES	;
PRIMARY SECONDARY R L		GR G	Fraccod to
MA STOOM THE THE THE	20 20 20 20 20 20 20 20 20 20 20 20 20 2	STZE (\$\frac{1}{2}\) [A]	B C Section 3A
I W I @ LOWER WWW.	122 324 124		
3A. ANY PLEURAL ABNORMALITIES CONSISTENT WITH PNYUMOCONIOSIS?	;	/ES Complete Sections JB and JC	NO Proceed to Section 4A
3B. PLEURAL PLAQUES (mark sure, cologication, ex. Chest mill Site Calculation	ens, and width) Estent (chest walk, combined for	1 1244	n profile ealy)
In profile ORLORL	en profile and face on) Up to 1/4 of lateral chest wall = 1	(3 mm) 3 to 5	maticum width require()
LAQ LAG	1Å to 1/1. of lacral chest wall = 2 > 1/2 of lacral chest wall = 3	5 cm 10: > 10:	mas=b
Dispirage ORL ORL			
Other proc(s) [O] R L   O R L	123 123		Proceed to
3C. COSTOPERENIC ANGLE OBLITERATION	R L Sersion 3D		NO Section 4A
3D. DIFFOSE PLEURAL TERCKENING (mark st extent, i	te, colosfication, Extent (chest wall, and width) in profile and face Up to 1.4 of W	. combined for eal) अंदार्थ क्षमा टोम्बर = 1	Width (in profile only) (3 mm minumum width required) 3 to 5 mm = a
Chert wall Calification	( स्थापना	neral chest wall = 2 meral chest wall = 3	> 10 ww = c 2 to 10 cm = p
ha profile ORL ORL			OR OL
Feet on ORL ORL	1 2 3	123	abc abc
4A. ANY OTHER ABNORMALITIES?	Y	ES Complete Sections 4B, 4C, 4D, 4E	NO Proceed to Section 5
4B. OTHER SYMBOLS (OBLIGATORY)			
Mark Mark Control of C			
QD if other diseases or agmificant chaoreszletect, Studings must be recorded on agreerse. (Section 4C/4D)  Dett. Physician or Worker agmified?  MONTH DAY YEAR			
4E. Should worker sea personal physician become of findings in section 47 YES NO			
5. FILM READER'S INITIALS 375		DATE OF READING	11 DA AL



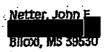
Jay T. Segarra, M.D., FACP

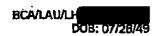
NIOSH Certified B-Reader

Board certified in Internal Medicine, Pulmonary Diseases, & Critical Care
Camellia Place • 2123 Government Street • Ocean Springs, Mississippi 39564
Phone/Fax (228) 872-2411

## OCCUPATIONAL LUNG DISEASE EVALUATION

November 9, 2004





HISTORY: This is a 55 year old welder Who reports exposure to welding dust, sandblasting dust, and asbestos dust during his work within a shipyard, over a twenty-five year period. He went to school through the twelfth grade. From 1974-1998, he spent twenty-four years working in a shipyard as a welder. He wore a welding hood. He welded inside and outside of ships. He removed old insulation from decks before welding. He worked around sandblasters, "every day," without respiratory protection. He states that the sandblasting dust fell down on his ciothes on a daily basis. He used fire blankets when welding and he did some grinding. He did not wear any respiratory protection, other than the welding hood, until the 1990s. Beginning in 1966, he has intermittently worked part-time in construction, as a cement finisher and brickmason in both commercial and residential settings. He lays bricks around the outside of houses and buildings. He mixes some mortar and some cement. He has not used any respiratory protection since he started doing this york in the 1960s. For the past year or so, he has worked as a housekeeper in a hospital.

He has smoked one-half of a package of cigarettes daily for the past thirty-three years, since beginning at age 22 in 1971 (16.5 pack-years). There is a family history of hypertension. His mother lived into her seventies. The patient himself has no significant past medical history and takes no medicine on a regular basis at this time. He is apparently allergic to aspirin. There is no prior history of lung disease, pneumonia, or chest trauma. He has had four surgeries on his right elbow over the past ten years.

on general systems review the patient reports stress-related indigestion and gas pains, "every once in a while." He gets cramps in his legs after walking about a block. He denies orthopnea, chronic cough, hemoptysis, wheezing, and significant dyspnea upon exertion. He believes that his exercise tolerance is normal and as good or better than other men his age. He has no respiratory symptoms at pleasant.

PHYSICAL EXAM: This is a pleasant middle-aged African-American man in no respiratory distress at rest. H: 75°; W: 216f; Puise: 76 and regular; B/P: 104/76. Head and neck: No adenopathy or jugular venous distention. Chest: Symmetric expansion. No obvious chest wall deformities. Lungs: Normal palpation and percussion. Clear to auscultation anteriorly and posteriorly to the bases. No rales, wheezes, or monch are heard. Heart: Regular rhythm, without murmurs, clicks, rubs, or gallops. Extremities: No clubbing, cyanosis, or edema.

CHEST X-RAY: PA and lateral views of the chest dated November 9, 2004 are reviewed for the presence of and classification of pneumoconiosis according to the ILO (1980) classification. Film quality is grade 2, due to scapular overlay. There is a diffuse nodular interstitial pattern consisting of small, rounded opacities of size and shape P/Q, ILO profusion 1/D in all six lung zones bilaterally. Examination of the pleural surfaces demonstrates no pleural plaques, pleural thickening, or pleural calcifications. No

110904.BCAlcal

Netter, John E. Page Two.

CHEST X-RAY: (Contrd) parenchymal infiltrates, effusions, nodules, or masses are present. The trachea is midline. The heart size is normal. The mediastinal structures are unremarkable. The costophrenic angles are sharp. There are no other significant intrathoracic findings. No previous films are available for comparison at this time. A high resolution chest CT may be useful in increasing the specificity of the interstitial findings for pneumoconiosis, should this test become dinically indicated due to either increasing pulmonary symptoms or declining lung function.

PULMONARY FUNCTION TESTING: Performed in Laurel, MS on November 9, 2004 using Crapo/Hsu predicted values. Forced vital capacity (FVO) is 5.58 litters (L), or 99% predicted (pred.). FEV1 is 4.42 i. (101% pred.). FEV1/FVC ratio is 79%. FEF 25%-75% is 4.48 i./sec. (114% pred.), SVC is 5.58 i. (99% pred.). TLC is 8.33 i. (104% pred.). DICO is 58% pred., based on an IVC of 5.47 I. inspection of the volume-time curves, flow-volume loops and diffusion graphs reveals good performance and reproducibility during those portions of the test. These pulmonary function tests, after race correction, demonstrate a mild reduction in diffusion capacity, in a current smoker, with otherwise normal spirometry and normal lung volumes.

**DIAGNOSIS/IMPRESSIDIL: 1284** Pulmonary Silicosis (mild chronic simple silicosis), based on the appearance of the chest x-ray and the exposure history. Although this condition is causing a mild diffusion impairment, it is currently asymptomatic. Additional radiographic correlation is suggested, when clinically indicated and available.

PROGNOSIS/RECOMMENDATION: Due to the long latency period between exposure to silica and the onset of clinically significant silica-related disease, the patient is at increased risk for the development of bronchogenic cardinoma, tuberculosis, and certain other conditions, as well as for deterioration in lung function, even in the absence of additional silica dust exposure. Since these conditions may occur many years after exposure has terminated, close clinical follow-up, annual pulmonary re-evaluation, and immediate smoking cessation are strongly recommended.

- Health Effects of Occupational Exposure to Respirable Crystalline Silica, National Institute for Occupational Safety and Health, Publication No. 2002-129, April 2002 Silica and Silica Induced Lung Diseases, Castranova V, Vallyathan V, Walkace W, CRC Press 1996 Boca Raton, 1.
- 2.
- Goldsmith p, "Silica Exposure and Pulmonary Cancer" in Epitlemiology of Lung Cancer, ed. Sammett J, 3. Marcel M. Decker, 1984.
- Recommendations For Control of Occupational Bafety and Health Hazards... Foundries, National Institute for Occupational Safety and Health, Division of Standards Development and Technology Transfer, 4 Publication No. 85-116, September 1985

110904 BCAlca)